PAST MEDICAL HISTORY: The patient's general health is good. He has no difficulties with heart disease, pulmonary disease or diabetes. He does not smoke and he drinks alcohol infrequently. He has no known medication allergies.

SOCIAL HISTORY: The patient has been married for eight years. He has a young daughter. He was on active duty with the Air Force for four years. He is 30% service-connected for a head and neck injury he suffered while in the Air Force. Currently, he drives a truck on Ft. Wainwright.

FAMILY HISTORY: The patient's father has a history of migraine headaches. There is no family history of stroke, Alzheimer's disease or epilepsy.

REVIEW OF SYSTEMS: Pulmonary - No shortness of breath. Cardiac - No chest pain. GI - No chronic nausea or diarrhea. All other systems are intact.

EXAMINATION: The patient is a slender young man who is dressed in his work clothes. He has short dark hair with blonde highlights in it. He is friendly and cooperative. His speech is clear without dysarthria or aphasia. He is alert and oriented in all spheres. His short-term memory is intact and he is able to remember four out of four words over five minutes. He can reverse the spelling of the word "world." He cannot reverse a five-digit sequence.

Cranial nerves II-XII are intact. On funduscopic exam, his disks are flat. On motor exam, tone is normal and there is no pronator drift. Finger-to-nose testing is done easily. Rapid alternating movements are intact bilaterally. Deep tendon reflexes are +2 and symmetrical with flexor plantar responses. Sensory exam is intact to pin, vibration, position and stereognosis. The patient's gait is normal and Romberg's sign is absent. He can tandem walk easily.

IMPRESSION: The patient has a normal neurological exam. I did review his presurgical MRI of the brain. He certainly had a sizable pituitary tumor which compressed the optic chiasm. He has had postoperative MRIs which show partial resection of the tumor.

I feel that the patient's headaches are primarily muscle tension headaches. They are rather atypical. Atypical elements of his history include the fact that his headaches are almost completely relieved by distraction. I encouraged the patient to not take any over-the-counter medications. We have started him on Elavil 10 mg before bed. We will see him back in a month and evaluate the results of treatment and the results of him being abstinent from overusing over-the-counter medications.

Ronald A. Martino, M.D.

RAM/cll
cc: Dr. Moffett (BACH)

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PSYCHOTHERAPISTS
KRISTEN BARTON, LPC

September 2, 2008

RE: Justin L. Olsen
DOB: 06/17/82
Our MR#: 95-15659

CHART NOTE

I obtained the radiologist's reports on the imaging studies which I reviewed at the time of Mr. Olsen's appointment. The radiologist sees no recurrent pituitary tumor since the patient's surgery.

The CT scan of the sinuses shows osteonecrosis at the right jaw joint. There is also early-forming osteoma in the frontal sinus.

ASSESSMENT: I believe the osteonecrosis can possibly be a trigger for the patient's headaches. Osteomas can also be a significant source of pain. We will have to see if the patient has had these findings evaluated by ENT.

Ronald A. Martino, M.D.

RAM/cll

EXHIBIT 10
Page 62 of 106

The patient's osteonecrosis in his right jaw is the result of a childhood surgery. This probably would not cause pain.

PLAN:

1. Beta-2 transferrin of CSF transferrin measurement and CSF discharge.
2. Increase Elavil to 20 mg before bed.
3. Return in one month.

Ronald A. Martino, M.D.

RAM/kys

cc: Dr. Tyler Moffett

faxed 10/30/08 MK

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PSYCHOTHERAPISTS
KRISTEN BARTON, LPC

October 2, 2008

RE: Justin Olsen
DOB: 6/17/1982
Date of Evaluation: 09/30/2008
Our MR#: 95-15659

Encounter Time: 30 minutes
Diagnostic Code: 784.0

FOLLOW-UP NEUROLOGICAL EVALUATION

CHIEF COMPLAINT: "I do not feel much different."

HISTORY: The patient states that when he initially started the Elavil his headache was significantly relieved for 4 or 5 days. The pain has now returned. He continues to have pain in his face and along the right side of his head. He is having no side-effects from Elavil 10 mg a day.

The patient came to the evaluation with his wife. She confirms that the patient is taking no over-the-counter medications. Despite the lack of over-the-counter medications, his headaches persist.

The patient states there may be a mild postural component to his headache. He notices when he gets up in the middle of the night, his headaches seem to get worse when he stands. During the day, however, his headaches tend to be intermittent. Sometimes lifting weights actually relieves his headache.

Both the patient and his wife notice that clear fluid drips from his nose. The fluid seems to drip without warning and has been occurring for at least several months.

SOCIAL HISTORY: The patient lives with his wife and child.

FAMILY HISTORY: No new family history.

REVIEW OF SYSTEMS: GI – No nausea or vomiting.

EXAMINATION: The patient is a slender man who is dressed in his work clothes. His speech is clear without dysarthria or aphasia. His mood appears to be normal. His gait is normal.

ASSESSMENT: I am concerned that the fluid dripping from the patient's nose may be spinal fluid. We will send him to the lab for a container so he could collect the fluid and get it tested for beta-2 transferrin. CSF rhinorrhea does not generally cause headaches. It would, however, put him at risk for infection.

The patient's MRI does not seem to show any recurrence of his tumor. There does seem to be a frontal sinus osteoma. Certainly osteoma has the potential to cause pain. The patient will try to get me the name of his ENT surgeon so that I could see what ENT thinks about his osteoma.

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PSYCHOTHERAPISTS
KRISTEN BARTON, LPC

October 2, 2008

Dr. Sean Demars
Bassett Army Community Hospital
Fort Wainwright, AK

RE: Justin L. Olsen
DOB: 6/17/1982
Our MR#: 95-15659

Dear Dr. Demars:

I am currently evaluating Justin Olsen for headaches. Mr. Olsen is a 26-year-old man who has a history of a pituitary macroadenoma which was partially resected. He currently has daily headaches.

On reviewing the patient's imaging studies, it was noted that he has an osteoma in the frontal sinus. I would like your opinion as to whether an osteoma in this location is likely to cause pain. Certainly I see an osteomas in other locations which have caused a great deal of pain. I, however, have no direct experience with osteomas in the wall of the sinuses.

Thank you for your assistance in this matter.

Sincerely yours,

Ronald A. Martino, M.D.

RAM/kys

EXHIBIT 10
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PSYCHOTHERAPISTS
KRISTEN BARTON, LPC

November 5, 2008

RE: Justin L. Olsen
DOB: 06/17/82
Date of Evaluation: 11/05/2008
Our MR#: 95-15659

Encounter Time: 30 minutes
Diagnostic Code: 784.0

FOLLOW-UP NEUROLOGICAL EVALUATION

CHIEF COMPLAINT: "I'm a little better."

HISTORY: The patient currently is taking 30 mg of Elavil a day. He does sleep soundly. He feels his mood is improved. His wife states he no longer curls up in a ball with bad headaches.

The patient continues to have daily headaches. He feels that when he works and keeps busy, his headaches are less severe. When he is idle, he suffers with them. He also feels when he washes out his sinuses, there is some improvement in his headaches. He states his headaches were best during the month after surgery, when he was on prednisone. When he stopped the prednisone, his headaches returned.

The patient's headaches are centered over his face and on the right side of his head. They are not accompanied by nausea, vomiting, or photophobia.

The patient did collect fluid from his nose. The fluid tested negative for spinal fluid. The patient has an ENT appointment this week.

SOCIAL HISTORY: The patient lives with his wife and child. His wife is currently pregnant.

FAMILY HISTORY: No new family history.

REVIEW OF SYSTEMS: GI - No nausea or vomiting. Psychiatric - The patient and his wife deny there is any significant depression. They feel that whatever element of depression there is came secondary to the headaches.

EXAMINATION: The patient is a slender man who is casually dressed. His speech is clear without dysarthria or aphasia. He appears to be somewhat depressed. His gait is normal.

ASSESSMENT: The patient seems to be improving with Elavil. We will increase his Elavil to 40 mg a day. We will see if the ENT surgeon feels the osteoma near the patient's frontal sinus is playing a role in his headaches. Eventually the patient will probably have to go back to the neurosurgical department at Madigan to see if the patient's surgical procedure has anything to do with his headaches. His headaches did start prior to the removal of his pituitary tumor.

PLAN:
1. Increase Elavil to 40 mg a day.
2. Return in one month.

Ronald A. Martino, M.D.

EXHIBIT 10
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PSYCHOTHERAPISTS
KRISTEN BARTON, LPC

December 11, 2008

RE: Justin L. Olsen
DOB: 06/17/82
Date of Evaluation: 12/11/2008
Our MR#: 95-15659

Encounter Time: 30 minutes
Diagnostic Code: 784.0

FOLLOW-UP NEUROLOGICAL EVALUATION

CHIEF COMPLAINT: "I still have headaches."

HISTORY: The patient is currently taking Elavil 60 mg a day. He is having at least partial control of his headaches. Sometimes the pain is over his face. The cold air at times improves the pain. Flushing his nose with saline sometimes improves the pain. The patient is having some mild sedation from the Amitriptyline.

We discussed the possibility of using Tegretol in the event this is some sort of atypical trigeminal dysfunction. The patient would prefer to increase the Elavil. He has 25 mg sized tablets at home. I instructed him to take 75 mg before bed.

The patient did consult with Dr. Raugust. Dr. Raugust did not find anything to explain his headaches. He did not think the osteoma was a problem. Dr. Raugust did note he had a swollen turbinate. The patient would like Dr. Raugust to operate on it. I cautioned the patient that Dr. Raugust specifically said in his consultation that this was not the cause of his headaches.

SOCIAL HISTORY: The patient works full-time and lives with his wife.

FAMILY HISTORY: No new family history.

REVIEW OF SYSTEMS: GI - No nausea or vomiting.

EXAMINATION: The patient is a slender man who is casually dressed. His speech is clear without dysarthria or aphasia. He appears to be mildly depressed. There is no loosening of associations or evidence of delusions. His gait is normal.

ASSESSMENT: The patient continues to have an atypical type of head pain.

PLAN:
1. Increase Elavil to 75 mg before bed.
2. Return in February 2009.

Ronald A. Martino, M.D.

EXHIBIT 10
Page 67 of 104

It should be noted that his headaches are beginning to take on some migrainous features. He has, however, been treated with Zomig.

PLAN:
1. Start Zoloft 50 mg a day.
2. Continue Tegretol XR 100 mg BID.
3. Return in four to six weeks.

Ronald A. Martino, M.D.

RAM/cll

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PSYCHOTHERAPISTS
KRISTEN BARTON, LPC

February 25, 2009

RE: Justin L. Olsen
DOB: 06/17/82
Date of Evaluation: 02/25/2009
Our MR#: 95-15659

Encounter Time: 30 minutes
Diagnostic Code: 784.0

FOLLOW-UP NEUROLOGICAL EVALUATION

CHIEF COMPLAINT: "I'm depressed."

HISTORY: The patient went to consult with a neurologist in Alabama. He did a lumbar puncture which was normal. He really had no opinion as to the cause of the patient's headaches. He did feel the patient was depressed and started him on Zoloft 50 mg a day. The patient has not yet started the medication.

The patient admits he has decreased energy and motivation. He feels depressed, but denies any thoughts of suicide. At times he feels tearful.

The patient has started Tegretol XR 100 mg BID. He started it a week ago. It was discovered that his chest pain was caused by bronchitis and not by the medication. He has no side-effects from the Tegretol.

The patient continues to have severe pain involving the top of his head and face. He is now getting some headaches accompanied by vomiting.

The patient plans to go to Madigan for a consultation there.

SOCIAL HISTORY: The patient lives with his family.

FAMILY HISTORY: No new family history.

REVIEW OF SYSTEMS: GI – No diarrhea.

EXAMINATION: The patient is a slender man who is casually dressed. His speech is clear without dysarthria or aphasia. At times he appears to be close to tears. There is no suicidal ideation. His gait is normal.

ASSESSMENT: We will have the patient start the Zoloft 50 mg every morning. He will continue Tegretol XR 100 mg BID until the middle of next week. He will consult by phone and we most likely will increase his Tegretol.

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PSYCHOTHERAPISTS
KRISTEN BARTON, LPC

June 11, 2009

RE: Justin L. Olsen
DOB: 06/17/82
Date of Evaluation: 06/09/2009
Our MR#: 95-15659

Encounter Time: 30 minutes
Diagnostic Code: 784.0

FOLLOW-UP NEUROLOGICAL EVALUATION

CHIEF COMPLAINT: "I'm doing better."

HISTORY: The patient is now taking Nortriptyline 20 mg before bed. He states that the headache type pains over the top of his head are much improved. He still has pain in his right jaw and pressure pain over his face.

We discussed the patient's most recent consultation. He was again given the opinion that he has a combination of muscle contraction headaches and migraine headaches. The patient expressed reluctance to accept this diagnosis, and to take medication indefinitely. He is hoping for some sort of surgical solution to his headache discomfort. He is thinking of consulting with Dr. Jensen or going to Mayo Clinic. J

The patient does have an appointment in Anchorage to have a sleep study done. He wakes up fatigued even after a full night's sleep. Arrangements have been made with his employer to have him work only the day shift.

The patient's trial on Indocin was unsuccessful. Tegretol XR did not relieve any of his pains. He is no longer taking Zoloft.

SOCIAL HISTORY: The patient lives with his wife and children.

FAMILY HISTORY: No new family history.

REVIEW OF SYSTEMS: Pulmonary – No shortness of breath.

EXAMINATION: The patient is a slender man who is casually and neatly dressed. His speech is clear without dysarthria or aphasia. He seems somewhat anxious, but not particularly depressed. His gait is normal.

ASSESSMENT: I have encouraged the patient to continue the current medication since it seems to be helping him. In a week he will increase the Nortriptyline to 30 mg a day.

PLAN: Return in two months.

Ronald A. Martino, M.D.

RAM/kys

EXHIBIT 10
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PSYCHOTHERAPISTS

KRISTEN BARTON, LPC

January 13, 2010

Peter Jiang, M.D.
FMH Pain Clinic
1919 Lathrop Street
Fairbanks, AK 99701

RE: Justin L. Olsen
DOB: 06/17/82
Our MR#: 95-15659

Dear Dr. Jiang:

I would like to refer Justin Olsen to you for treatment. Mr. Olsen suffers from severe migraine headaches. Many of his headaches are triggered by severe muscle spasm in his right jaw and right side of his neck. I feel that if he could receive trigger point injections to those areas, this might reduce the frequency and severity of his headaches.

Mr. Olsen is 27 years old and in good general health. He did have a macroadenoma surgically removed several years ago. His headaches started at that time.

The patient has had a recent evaluation at the Mayo Clinic, where it was felt he was suffering from migraine headaches.

Thank you for your assistance.

Sincerely yours,

Ronald A. Martino, M.D.

RAM/cll

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PSYCHOTHERAPISTS
KRISTEN BARTON, LPC

January 13, 2010

RE: Justin L. Olsen
DOB: 06/17/82
Date of Evaluation: 01/13/2010
Our MR#: 95-15659

Encounter Time: 30 minutes
Diagnostic Code: 784.0

FOLLOW-UP NEUROLOGICAL EVALUATION

CHIEF COMPLAINT: "I went to the Mayo Clinic."

HISTORY: The patient went to an evaluation at the Mayo Clinic. They found he had a somewhat elevated growth hormone level. Otherwise, they told him he had migraine headaches. They have prescribed Topamax 25 mg twice a day with an escalating dosage schedule.

I told the patient I thought he had taken Topamax in the past, but we were unable to find documentation of that. I therefore advised him to follow through with the Topamax.

The patient feels he has extreme muscle tightness in his jaw and neck. This seems to trigger many of his migraine headaches. We prescribed a lidocaine patch to be used at night on the neck and jaw since that is when the pain was most problematic.

The patient states Ambien did not help him sleep. Five milligrams of Valium helped him sleep since it reduced the muscle tightness in his jaw and neck. We therefore agreed to prescribe him Valium.

SOCIAL HISTORY: The patient lives with his wife. At times he has headaches with vomiting which prevents him from working.

FAMILY HISTORY: No new family history.

REVIEW OF SYSTEMS: Ophthalmologic - The patient states he was leaning over the engine of his vehicle when the hood came down and struck him in the back of the head. He injured his eye and forehead on the radiator. He is currently undergoing treatment for those injuries.

EXAMINATION: The patient is a slender man who has a sutured wound on his forehead. There are ecchymoses around the left eye with ecchymosis of the conjunctiva of the left eye. His speech is clear without dysarthria or aphasia. He is somewhat depressed. His gait is normal.

ASSESSMENT: We will follow through with treating the patient with Topamax. He will try the Lidoderm patch. We will also refer him to Dr. Jiang for possible trigger point injections.

EXHIBIT 10
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PLAN:
1. Lidoderm patch.
2. Topamax.
3. Return in 4-6 weeks.

Ronald A. Martino, M.D.

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PSYCHOTHERAPISTS
KRISTEN BARTON, LPC

February 16, 2010

RE: Justin L. Olsen
DOB: 06/17/82
Date of Evaluation: 02/16/2010
Our MR#: 95-15659

Encounter Time: 30 minutes
Diagnostic Code: 784.0

FOLLOW-UP NEUROLOGICAL EVALUATION

CHIEF COMPLAINT: "I may get jaw surgery."

HISTORY: The patient has a consultation in a month concerning surgery on his jaw. His doctor thinks the jaw misalignment on the right is acting as a trigger for the patient's headaches.

The patient stopped Topamax. He occasionally takes 5 mg of Valium at night or Vicodin ES at night. He states the medication helps him sleep. If he gets a good night's sleep, his headaches will not occur until late in the afternoon the next day.

I suggested to the patient that he try Zanaflex 4 mg before bed. It is a muscle relaxant, yet it also acts centrally in the brain to prevent other headache types. We discussed the possibility of drowsiness or skin rash.

SOCIAL HISTORY: The patient works full-time. He lives with his wife.

FAMILY HISTORY: No new family history.

REVIEW OF SYSTEMS: GI - No nausea or vomiting.

EXAMINATION: The patient is a slender man who is casually dressed and neatly groomed. His speech is clear without dysarthria or aphasia. He is alert and well oriented. His gait is normal.

ASSESSMENT: We will try Zanaflex 4 mg before bed.

PLAN:
1. Zanaflex 4 mg before bed.
2. Return after surgery.

Ronald A. Martino, M.D.

RAM/cll

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PSYCHOTHERAPISTS
KRISTEN BARTON, LPC

June 30, 2010

RE: Justin L. Olsen
DOB: 06/17/82
Date of Evaluation: 06/29/2010
Our MR#: 95-15659

Encounter Time: 30 minutes
Diagnostic Code: 784.0

FOLLOW-UP NEUROLOGICAL EVALUATION

CHIEF COMPLAINT: "I'm doing okay."

HISTORY: Currently the patient takes Klonopin 1 mg before bed and Relafen 750 mg once a day. He found that if he took Relafen twice a day, he was far too drowsy. Even on his current dosages, he feels somewhat drowsy at times. He states he is going to try to decrease his Klonopin to 0.5 mg a day to see if he can get the same benefit without drowsiness.

On most days the patient has a pain of approximately three on a scale of 1-10. On occasional days his pain is as high as a 5 or a 6.

His pain continues to start at his right jaw and radiate to his head and face. He is tentatively scheduled for surgery on his right TMJ in August.

The patient talked about how his psychological state affects his pain. If he does not get enough sleep, his pain is worse. If he is worried about something his pain is worse. When he is at work and being distracted, his pain is better. He finds that if he drinks a Red Bull, he feels much better. He, however, is afraid to drink a Red Bull everyday.

The patient would like to do a trial of Lyrica. He states he will reduce the Klonopin first, and at some point will try Lyrica for his pain.

SOCIAL HISTORY: The patient lives with his wife and children.

FAMILY HISTORY: No new family history.

REVIEW OF SYSTEMS: GI – He has an occasional upset stomach.

EXAMINATION: The patient is a slender man who is dressed in his work clothes. His speech is clear without dysarthria or aphasia. He seems somewhat anxious. His gait is normal.

ASSESSMENT: The patient will try reducing his Klonopin to 0.5 mg daily. He will continue to take Relafen 750 mg once a day. At some point we will start a trial of Lyrica.

EXHIBIT 10
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PLAN:
1. Decrease Klonopin to 0.5 mg before bed.
2. Continue Relafen 750 mg once a day.
3. Return in four months.

Ronald A. Martino, M.D.

RAM/kys

FAIRBANKS PSYCHIATRIC AND NEUROLOGICAL CLINIC, P.C.

Patient Medication Chart

Name Olsen Justin

Date	Medication/Dose	Instructions	No.	Refills	M.D.	Pharmacy
10/21/08	↑ Effexor	150mg	ii tabs q hs			
11/5/08	↑ Effexor	150mg	Four tabs q hs	#120	x2	Walgreens
12/11/08	↑ Effexor	225mg	iii tabs q hs	[illegible] no supply		
12/30/08	Taper Effexor					
	Nemenda	300mg	i q hs	#30	x1	College Sch
1/6/09	Nemenda	300mg	i bid			
1/12/09	Vecuronium	300mg	i PO BID	#60	x1	10/ADF 63
1/26/09	Tegretol XR	200mg	100mg i tab bid	#60	x1	631
	Nemenda	Old hx psych.				
2/10/09	Medication - Tegretol XR stopped by pt					
2/25/09	Zoloft	50mg	i tab qm, Delph.			
	Cymbalta	Tegretol XR	100mg bid			
3/3/09	↑ Tegretol XR	100mg	ii tabs bid			F6:
3/18/09	Tegretol XR	100mg	ii tabs qam bid	#120	x1	
4/10/09	Taper off Tegretol XR					
4/24/09	Trileptal	150mg	i tab bid	#90	Sch	Walgreens
5/1/09	↑ Trileptal	150mg	ii bid			
5/19/09	D/C Trileptal					
	Nortriptyline	10mg	i tab q hs	#30	x1	Sch 631
6/9/09	↑ Nortriptyline	10mg	ii tabs q hs			
6/15/09	↑ Nortriptyline	10mg	iii tabs q hs	#90	x1	Sch 631
7/14/09	Nortriptyline	10	iii hs	#90	x1	631
7/21/09	Nortriptyline	10mg	Five tabs q hs			
7/29/09	Nortriptyline	50mg	i PO QHS	#30	x1	140 63
9/15/09	Nortriptyline	50mg	i po q hs	#30	x2	Rideout
9/14/09	Nortriptyline	25mg	iii q hs	#90	x2	

EXHIBIT 10
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Quest Diagnostics®

QUEST DIAGNOSTICS INCORPORATED

1 15659

PATIENT INFORMATION
OLSEN, JUSTIN

DOB: 06/17/1982 AGE: 26
GENDER: M FASTING: U

ID:
PHONE:

REPORT STATUS FINAL

ORDERING PHYSICIAN
MARTINO, RONALD A

CLIENT INFORMATION
N38007807 MAILOUT
FAIRBANKS PSYCH & NEURO CLINIC
1919 LATHROP ST STE 220
FAIRBANKS, AK 99701-5936

SPECIMEN INFORMATION
SPECIMEN: NW888919M
REQUISITION: 2267897

COLLECTED: 10/31/2008
RECEIVED: 10/31/2008 17:56 PT
REPORTED: 11/04/2008 14:50 PT

Test Name	In Range	Out of Range	Reference Range	Lab
BETA-2 TRANSFERRIN, BODY FLUID				EO
BETA-2 TRANSFERRIN, BF	Negative			

-- EXPECTED VALUES --
Negative, no beta-2 transferrin (spinal fluid) detected.
Research Use Only

PERFORMING LABORATORY INFORMATION
EO MAYO MEDICAL LABORATORIES, 200 FIRST STREET, SW, ROCHESTER, MN 55905, Laboratory Director: FRANKLIN R COCKERILL,III,MD
CLIA: 24D0404292

EXHIBIT 10
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MEDICAL RECORD | CONSULTATION SHEET Page 1 of 7

Consult Request: Consult

|Consult No.: 2250927

To: NEUROLOGY INTERFACILITY (SEA)
From: ALASKA VAHSRO |Requested: 02/11/2009 9:04 am

Requesting Facility: ALASKA VAHSRO
Remote Consult No.: 383524
Role: Consulting facility

REASON FOR REQUEST: (Complaints and findings)
pt requests consultation with VA neurologist

HEADACHES
regular headaches, throught the day
does not notice them as much when he is busy but becomes aware of them when he is sitting around or his mind is less engaged.
headaches much worse when he is tired
headaches respond to Fiorecet but not to zolmatriptan.
He has had a headache that responded to sumatriptan.
MRI brain 4/08: neg for any abnormalities other than stable post-pituitary adenoma resection changes.
CT sinus 3/08: negative
saw Dr. Recupero (BACH ENT) who said that the CT scan showed some jaw DJD.
Dr. Demars (BACH ENT) 3/08: possible sinusiits, given levofloxacin
Dr. Demars ENT BACH: flexible nasendoscopy 8/08 negative, possibly migraine
Pt denied any jaw crepitus/popping or worsening pain with chewing but does have stiffness.
accupuinture 5/08 seemed to help, has had 6 treatment
mandible reconstruction as a child
CT 3/08: gross deformation of right mandibular component of TMJ
Has seen dentist (Helmrick) 6/10/08: bite is off, wanted to fix fillings
PT took some measurements, was going to talk to Dr. Brock
saw Dr. Brock (orofacial surg) 6/19/08: took film, considered surgery
was seen by Dr. Sutley (orofacial) is took over from Dr. Brock, who referred him to pain clinic
relocating
Dr. Martino (Neuro) though not to be migraines, stopping medications, Tylenol #3s have been stopped
beta-2-transferrin neg (10/08)
Dr. Martino (Neuro) concerned about whether a frontal sinus

AUTHOR & TITLE: |DATE:

ID #:_____|ORGANIZATION: PUGET SOUND HCS |REG #:____ |LOC: ALASKA VAHS

OLSEN,JUSTIN LEE SC LESS THAN 50% SC VETERAN
574-72-3179 06/17/1982
1075 Cloverleaf Dr.
NORTH POLE ALASKA 99705 Phone: (907) 490-2417

CONSULTATION SHEET
Standard Form 513 (Rev 9-77)

EXHIBIT 10
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MEDICAL RECORD | CONSULTATION SHEET Page 2 of 7

Consult Request: Consult

Consult No.: 2250927

Reason For Request continued.

osteoma may be cause for headaches.
was referred to VA Neurology for second opinion but was fee'd back to Dr. Martino.
Dr. Martino: unsuccessful trial of gabapentin, also caused fatigue. Trial on carbamezepine causing chest pain.
ENT sinus surgery 12/18/08 Dr. Raugust: no change in facial pressure
has been taking some diazepam/cyclobenzaprine at night
felt better on amitriptyline but needs increasing doses which causes sedation at or above 70 mg cause severe "grogginess"
saw neurologist, Dr. Gory, in Dotham, AL while on vacation: had spinal tap, also checked for spinal fluid leak which was reportedly negative. Was given Zoloft but pt is not taking. Has pending test results
A: still unclear cause
P: await test results. Pt requests VA Neurology appt.

PROVISIONAL DIAG: headache

REQUESTED BY:	PLACE:	URGENCY:
MOFFETT,TYLER C MD	Consultant's choice	Within 1 mo
(Pager:)	SERVICE RENDERED AS:	
(Phone: (907)361-6370)	Outpatient	

CONSULTATION NOTE #17343960

LOCAL TITLE: NEUROLOGY CONSULT REPORT
STANDARD TITLE: NEUROLOGY CONSULT
DATE OF NOTE: MAY 18, 2009@09:10 ENTRY DATE: MAY 18, 2009@09:10:29
AUTHOR: OZUNA,JUDITH M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

26 yo male referred to neurology for headache.

HPI:
HA started summer '07, forehead throbbing - can't remember much else
This led to diagnosis of pit. adenoma which was resected transphenoidally at Madigan 8/07. Some tumor remains, but pt. has not field cuts or other residual, x HA. On no hormone replacement.

Since surgery he has nasal/central face pain "like having an allergy" - pressure in B cheeks.

HA began 2 mo's after surg., when he tapered off prednisone. 6/10 pain, awakens with HA, lasts off and on all day, in vertex and mid forehead, constant pressure, occas. nausea/vomiting (esp. if poor sleep), photophobia, some phonophobia, eyes hurt.